

Local payment examples

Improving Access to Psychological Therapies: a local payment case study

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Purpose of this document

The Improving Access to Psychological Therapies (IAPT) programme for adults (over 18), launched in 2008, aims to make evidence-based psychological therapies for depression and anxiety disorder more widely available in the National Health Service. This paper describes an approach to payment for providers of IAPT services that systematically links the final amount of payment a provider receives to recorded patient outcomes as well as the provider's levels of activity. It is intended for use by commissioners and providers for commissioning psychological therapy services which meet the IAPT standards,^{1 2} It builds on work undertaken by the Improving Access to Psychological Therapies (IAPT) programme and supports the NHS in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people with depression and anxiety disorders by commissioning the appropriate psychological therapies.

This document details a possible payment approach that can be considered when developing contractual arrangements during 2015/16. The approach is consistent with the '2015/16 National Tariff Payment System' local price setting rules and supporting guidance on Mental Health Currencies and Payment.

The IAPT payment approach links explicitly with the currency design for secondary mental health for working age adults and older people. All people coming into an IAPT service will, as part of their initial clinical assessment, be assessed using the Mental Health Clustering tool.³ This has two purposes, firstly to identify the intensity of treatment likely to be required and therefore the appropriate level of payment, and secondly whether in fact the service user may need referral on to secondary mental health services. The payment approach described below explains how payment will partly be determined by the level of need, as identified through the Mental Health clustering tool, and partly through the outcomes that are being achieved.

Outline of the issue

IAPT impact on mental health

The available evidence states that approximately 25% of the adult population in England will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time, with depression and anxiety the most common.⁴ Depression and anxiety disorders are serious and debilitating conditions, and have significant impacts on the quality of life for individuals and their families, and wider economic costs. The relevant NICE

¹ Improving Access to Psychological Therapies (IAPT)

² www.iapt.nhs.uk/silo/files/iapt-for-adults-minimum-quality-standards.pdf

³ <https://www.gov.uk/government/consultations/national-tariff-payment-system-201516-a-consultation-notice>

⁴ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

Guidelines say that people diagnosed with these conditions should be offered evidence-based talking therapies as an effective treatment; this is also a service that most people with these problems want.⁵

Further, the Department of Health strategy for Mental Health, 'No Health without Mental Health' (2011),⁶ points out that improving equitable access to psychological therapy is fundamental to ensure improvements to:

- the mental health and well-being of the population and
- outcomes for people requiring mental healthcare.

The IAPT programme for adults (over 18 years old) has supported increased access to NHS commissioned services for depression and anxiety in England since 2008. Before the IAPT programme, psychological therapy services provided for people with depression and anxiety disorders were often not evidence-based, with inconsistent quality standards and patchy geographical provision.

Psychological therapies are now seen as an important element of the package of care for people with depression and anxiety disorders. For many of these people IAPT therapies may be the only type of mental healthcare that they need.

The IAPT programme has brought in therapies with a robust evidence base, a stepped model of care, a workforce trained to meet the requirements of a national curriculum, and the routine monitoring of patient-reported outcome measures at every contact. It supports NHS commissioners in delivering:

- NICE-approved, evidence-based psychological therapies for people with depression and anxiety disorders
- equitable access to services and treatments for people experiencing depression and anxiety from all communities within the local population
- increased health and wellbeing, with at least 50% of those completing treatment moving to recovery and most experiencing a meaningful improvement in their condition
- patient choice, and a high level of satisfaction from both people using services and their carers
- timely access, with people waiting no longer than the locally agreed waiting times and

⁵ 8 See for example McHugh et al. (2013), Chilvers et al. (2001), Deacon and Abramowitz (2005) and van Schaik et al. (2004).

⁶ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

- improved employment, benefit, and social inclusion status, including help for people to retain employment, return to work, improve their vocational situation and participate in the activities of daily living.

IAPT impact on physical health and medically unexplained symptoms

It is important to note that although there are direct costs attributable to the incidence and prevalence of anxiety and depression these give a very incomplete account of the overall impact of these conditions. For example, nearly a third of all people with long-term physical conditions have a co-morbid mental health problem, in many cases depression or anxiety. These mental health conditions raise the costs of delivering their physical health-care by at least 45% for a wide range of conditions, including cardio-vascular disease, diabetes and respiratory conditions at each level of severity, costing at least an additional £8 - £13 billion a year⁷.

Moreover, half of all patients referred for first consultant appointments in the acute sector have medically unexplained symptoms, such as back pain, chest pain and headache. These patients cost the NHS some £3 billion a year,⁸ and in many cases if a consistent approach to assessment and treatment of underlying mental health needs was undertaken some of the costs could be reduced. So, if we add in the £8 to £13 billion or more above, untreated mental illness could be costing the NHS up to £16 billion each year in physical healthcare costs.

What does a good IAPT service look like?

Based on the available clinical evidence, a good IAPT service will offer an integrated but stepped approach to care, appropriate to the needs of those people accessing the service. The model of stepped care is described in Annex A. Services should think about patient needs in a holistic way, for example, by having employment advisors in the team to support individuals who are receiving treatment, and employment co-ordinators who work with employers in order to help service users gain or retain employment. The service should also be able to offer psychological therapies for complex cases, but have the skills to identify when other support needs to be brought in. Services should offer a choice of therapies, practitioner (including gender) and treatment location, and should focus on prompt access to services and seek to engage harder to reach groups.

A recent workshop with a number of high performing IAPT services identified a range of key quality markers, not all of which are exclusive to IAPT, but which include:

⁷ <http://www.kingsfund.org.uk/publications/long-term-conditions-and-mental-health?qclid=ClfRsP3o2MACFabMtAodsnYASQ>

⁸ Bermingham, S., Cohen, A., Hague, J. and Parsonage, M. (2010), "The cost of somatisation among the working-age population in England for the year 2008-2009", *Mental Health in Family Medicine*, 7: 71-84.

- **Excellent leadership, with a real focus on recovery:** the overarching requirement for good leadership is not only at senior level but at team level, and includes: feedback of individual therapist performance, individually tailored Continuing Professional Development (CPD) for staff; benchmarking and active decision making by the whole team; individual accountability; and a culture of enquiry.
- **Optimised performance management systems:** including clinical supervision with a focus on data and recovery performance; accessible, reliable and complete data; tracking outcomes at an individual therapist level, and including this as part of performance management activity; good clinical productivity.
- **Workforce stability and experience:** the best performing providers have good retention rates and experienced workforces.
- **Assessment and access:** providers put an emphasis on correct assessment and getting the patients to the right therapists within waiting time targets – this includes an accurate judgement of their presenting problems (including provisional diagnosis using ICD10 codes).
- **Choice of NICE compliant treatments and access to alternative pathways:** discussing treatment choices with patients and identifying step-up or step-down options when appropriate.
- **Flexible number of sessions fitting clients' needs:** well performing providers generally had an open-ended approach to the overall number of sessions that could be offered. However, therapists and clients discussed sessions in terms of relatively short 'blocks' in order to help focus therapist and client on making progress (eg six sessions followed by a review and further such blocks as appropriate).
- **Commissioning:** commissioning has a significant role to play in high performing services, ensuring investment and sensible contracting, monitoring and discussion of outcomes, and avoiding perverse incentives.
- **Data informed, service level reflective practice:** dramatic and sustained increases in recovery rates (45% to 65%) have been achieved by systematically reviewing all non-recovered cases and taking specific actions on the themes identified as reasons for non-recovery.

IAPT services can take specific actions to improve rates of recovery. For example, one service took the following steps:

- completing a comprehensive review of clinical notes for all patients discharged not recovered in service
- identifying themes/ common patterns in the data

- creating a monthly performance benchmark report for individual therapists focused on attendance, recovery rate, DNA rate, completion rate, targets, for their caseload
- modifying certain operational procedures, particularly in relation to training and supervision to more explicitly focus on recovery
- explicitly supporting staff in aspiring for higher than minimum recovery – at least 65% for example.

Outline of the opportunity

To support the roll out of IAPT compliant services, a payment approach has been developed that rewards providers for delivering outcomes. Outcomes that matter to people and support their daily activities are described by a series of metrics. Commissioners can use the metrics and payment approach to identify the most effective service providers and hold them to account for making progress in meeting local needs. A large number of published materials are available on the IAPT website⁹ to support those health economies who want to move to an outcomes-based payment approach.

Underpinning the roll out is the assumption that the delivery of effective, evidence based treatments in a consistent manner will improve clinical recovery rates realising a range of clinical and non-clinical benefits such as employment and/or well-being improvements to the individual, their families, local communities and the wider economy.

There is emerging robust evidence that the impact of rolling out IAPT compliant services can be significant and achieved relatively rapidly. For example, a general practice in England recently followed up a large cohort of its patients who had been referred to IAPT. It looked at how patterns of healthcare utilisation and therefore costs had changed between the period before referral and two years later. Some of the patients had not received IAPT treatment, some had received partial treatment and some had received full IAPT treatment. By comparing matched samples of treated and untreated patients it was possible to estimate how the treatment had affected their usage of physical healthcare. This short study found that annual expenditure overall had fallen substantially for the groups receiving IAPT treatment.

Following testing of the payment approach over the past 3 years it is now becoming sufficiently robust for local areas to consider using it. The approach requires local prices to be agreed but to assist negotiations Monitor and NHS England plan to make available some non-mandatory benchmark prices later in the year.

⁹ www.iapt.nhs.uk/iapt/

Benefits of implementing an outcomes based payment approach

An outcomes based payment approach for IAPT allows commissioners to incentivise delivery of the outcomes that matter to them locally, for example improving access by older people or ethnic minorities, or readiness for employment.

Benefits to patients: As part of the payment is focused on achieving improved well-being for patients, providers will not only be focused on good clinical outcomes but also meeting the wider needs of people being seen. Improved mental well-being is an important objective in its own right for patients, but the benefits can extend into many other aspects of life, including physical health.

- Having a mental health problem increases the risk of physical ill health. Co-morbid depression doubles the risk of coronary heart disease in adults and increases the risk of mortality by 50%.
- Mental health problems such as depression are much more common in people with physical illness. Having co-morbid physical and mental health problems delays recovery from both. People with one long term condition are two to three times more likely to develop depression than the rest of the population. People with three or more conditions are seven times more likely to have depression.
- Adults with both physical and mental health problems are much less likely to be in employment.
- People with mental health problems are less likely to benefit from mainstream screening and public health programmes.
- People with mental health problems have higher rates of respiratory, cardiovascular and infectious disease, and of obesity, abnormal lipid levels and diabetes. On average people with mental health problems have a life expectancy 16–25 years less than the general population.¹⁰

Transparency about the outcomes that are being achieved by services will also help patients to make meaningful choices about the providers they decide to use. A local price will allow money to follow the patient and support more active choices being made.

Benefits to providers: Providers are incentivised to manage their services to deliver the best possible care and will be rewarded for achieving good outcomes. Financial risks will be more effectively shared with commissioners.

Benefits to the commissioners: Commissioners can assure the quality of service provision through measuring outcomes, patient satisfaction and the choices

¹⁰ Statistics from the Department of Health's mental health strategy 2011

offered by providers. The proportions of payment allocated to various aspects of the model can be flexed to reflect local needs and strategic ambitions in terms of factors such as access and non-clinical benefits. Financial risks and rewards will be more effectively shared with providers.

Benefits to the system: Significant opportunities exist for providing cost-effective early interventions to support people experiencing low level mental health problems, while payment linked to outcomes increases the ability to monitor performance and achievements, and the impact on costs in the system.

Examples of outcomes based IAPT services

The Coventry, Warwickshire and Solihull IAPT Service was established in 2009 and has received almost 100,000 referrals since that time. The service offers a range of evidence based NICE approved psychological interventions in a timely, accessible and effective manner. This has revolutionised care for people with common mental health problems and has the following key service features.

Clinical outcomes

The treatments offered by the service are highly effective and evidence based; over 50% of people accessing treatment last year recovered and a further 15% of people achieve what is known as 'statistically reliable improvement' as measured through the clinical outcome tools which form part of the model (see the currency model description).

Accessibility

- Self-referral - of the 20,000 referrals received last year just under 75% were self-referrals – this percentage increased further by Q4.
- Centralised telephone booking service - patients can contact the service directly and get booked in to an assessment slot at the most convenient time for them.
- Drop in clinics – offer an alternative to a telephone assessment for those that may struggle with this type of appointment and gives flexibility.
- Clinics held in GP surgeries and community venues – working alongside other agencies to improve access for harder to reach groups e.g. Age UK, those with a co-morbid substance misuse problem.
- The service works to reduce waits to a minimum; the majority of people receive assessment within 7 days and treatment starting within 28 days of referral.

Choice

- The service provides and promotes a stepped care model of treatment offering the least intrusive and least intensive treatment first, when clinically appropriate. The service provides a range of interventions including guided self- help, psycho-education, group and individual therapies including Cognitive Behavioural Therapy, Counselling for Depression, Interpersonal Therapy, Dynamic Interpersonal Therapy and Mindfulness Based Cognitive Therapy. Good staff training has been crucial in assuring effective and consistent delivery.
- The service is a partnership between the Coventry and Warwickshire NHS Trust and Coventry and Warwickshire MIND. Effective partnership working enables the skills and experience of the NHS and third sector to be combined to meet the needs of all those with depression and anxiety in Coventry, Warwickshire and Solihull.

Patient experience

- Overall satisfaction levels at assessment, information & communication including choice and treatment are in excess of 90%.
- Quotes from our patients: “To be honest, I was dreading this experience but it turned out to be the best thing I have ever done. I look forward to it every week and feel I resolve something after every session.” “Six months ago, I felt that life was mainly surviving from day to day. Now I look forward to getting up, planning for the future and enjoying range of experiences.”

What are the key enablers?

- Fidelity to the IAPT model – a clear outcome focus and ‘step up’ from low intensity to high where required which is clear and smooth for the patient.
- Effective clinical leadership and supervision.
- Robust reporting and monitoring – using data to understand capacity, demand, activity and performance.
- Skilled workforce – ensuring a workforce is in place with the appropriate skills, knowledge and experience.
- IAPT Payment pilot - In depth analysis of performance and costs as a result of participation in the IAPT Payment pilot, has led to improved effectiveness.

Trent Psychological Therapies Service (Trent PTS) is an independent psychological therapies provider delivering IAPT services across Derbyshire under an Any Qualified Provider contract. The service was developed and launched in 2009 as part of the roll out of IAPT Services across the East Midlands.

Service model

The service model is unusual in that the delivery team is made up of 42 high intensity therapists delivering both High and Low Intensity treatment within a Stepped Care Model. The service offers a comprehensive range of NICE approved psychological therapies within a multidisciplinary team structure including:

- low/high intensity cognitive behavioural therapy
- interpersonal psychotherapy
- behavioural couples therapy
- counselling for depression and
- dynamic interpersonal therapy.

When a patient is 'stepped Up' there is no transfer of the patient but the level of intervention by the therapists is stepped up. This has led to fewer dropouts and no waiting times between transitions from low to high intensity therapy. This model of delivery means there are no interruptions or waits between steps.

Case management is at the core of the operational processes with excellent feedback systems to clinicians to ensure targeted supervision and continuous professional development (CPD).

Access

The service operates 9am to 7pm to enable easier access to appointments for those with work commitments. All patients are given choice of location and time of assessment and assessments are normally offered within 10 days of referral. Treatments begin within the 28 day target. Access to the service is broad and referrals are accepted from GP's and other primary care clinicians, secondary care mental health services, third party referral from social services, Job Centre Plus and voluntary services, as well as self-referral.

The service has used the flexibility in the referral pathway to create strong links with Job Centre Plus, BME communities and more difficult to reach groups. The informal referral pathway has resulted in 79% of all referrals, including those initiated by a GP, using a self-referral pack or online referral to the service, with the majority of referrals coming via this route, which improves compliance and begins the process of clinical engagement before entering the service. 20% of referrals come from black and minority ethnic (BME) groups and other hard to reach groups.

The service meets and exceeds all IAPT targets including recovery rate, access rate, and the 28-day referral to treatment target. At 17%, Derbyshire is achieving local access rates above expectation.

Outcomes

The service has very robust case management processes and these are linked to supervision and CPD. The Service completes around 4500 treatments per year with a recovery rate of 58% as measured by the number of cases who achieved caseness¹¹ at the start of therapy but no longer achieve caseness on IAPT measurement upon completion. In terms of reliable improvement, the service achieves this in 69% of cases. The completion rate of those who attend for assessment is 71%.

The service consistently received very high satisfaction rates among service users, primary care teams and other referral agencies.

The payment design

Introduction

The IAPT payment approach is designed to reward outcomes but recognises the need to balance this with at least an element of activity-based payment. The approach therefore has the following features:

- a basic service price for each of the mental health clusters that IAPT services are expected to treat and for each assessment that the service undertakes; and
- a performance payment based on the overall results achieved by the service.

This first feature draws upon the fact that all patients coming into an IAPT service will, as part of their initial clinical assessment, be assessed using the Mental Health Clustering tool,¹² This will be a core element of the payment structure as it is known that there is close correlation between complexity as indicated by the cluster and treatment cost.

Patients allocated to higher clusters are significantly more likely to require high intensity treatment. Therefore cluster based episode prices can be used to incentivise treatment of more severe cases avoiding perverse incentives to 'cherry pick less complex cases.

¹¹ An individual is said to be at caseness when their outcome score exceeds the accepted threshold for a standardised measure of symptoms. (Further detail is available in 'The IAPT Data Handbook', available from www.iapt.nhs.uk/services/measuring-outcomes/

¹² <https://www.gov.uk/government/consultations/national-tariff-payment-system-201516-a-consultation-notice>

This second feature is key and gives commissioners the ability not just to reward providers for achieving or exceeding desired levels of activity, but influence provider delivered outcomes by adjusting the relative level of reward associated with individual performance measures.

To maintain services it is essential that providers can cover their costs. Therefore the local price design must **not** be set in such a way that full cost recovery can only be achieved if all the access targets and outcomes are met in full. However, it is appropriate to set a local price that requires agreed outcomes to be achieved and which incentivises improvement.

With this in mind, it is therefore suggested that in order not to destabilise providers financially in the short-term, the performance element could be set, in the first instance, at a low percentage of the overall contract value, and certainly no more than 50%. However, to be clear, continued provision will be contingent upon long-term performance. Therefore, while it is recommended that implementation is at least initially based on a combination of activity payments (for assessments and cluster based treatments) with outcomes payments, the strategic direction should be towards increasing the proportion of payment earned through outcome performance. As such, in subsequent years the performance element could be increased, say over a period of five years, to the point where it is as much as 100% of the contract payment. However, this must be carefully modelled to ensure that the lack of guaranteed payment, other than for initial assessments, will not result in good providers withdrawing from service provision, nor create perverse incentives in the choice of care options offered to service users.

The outcome element of the payment approach

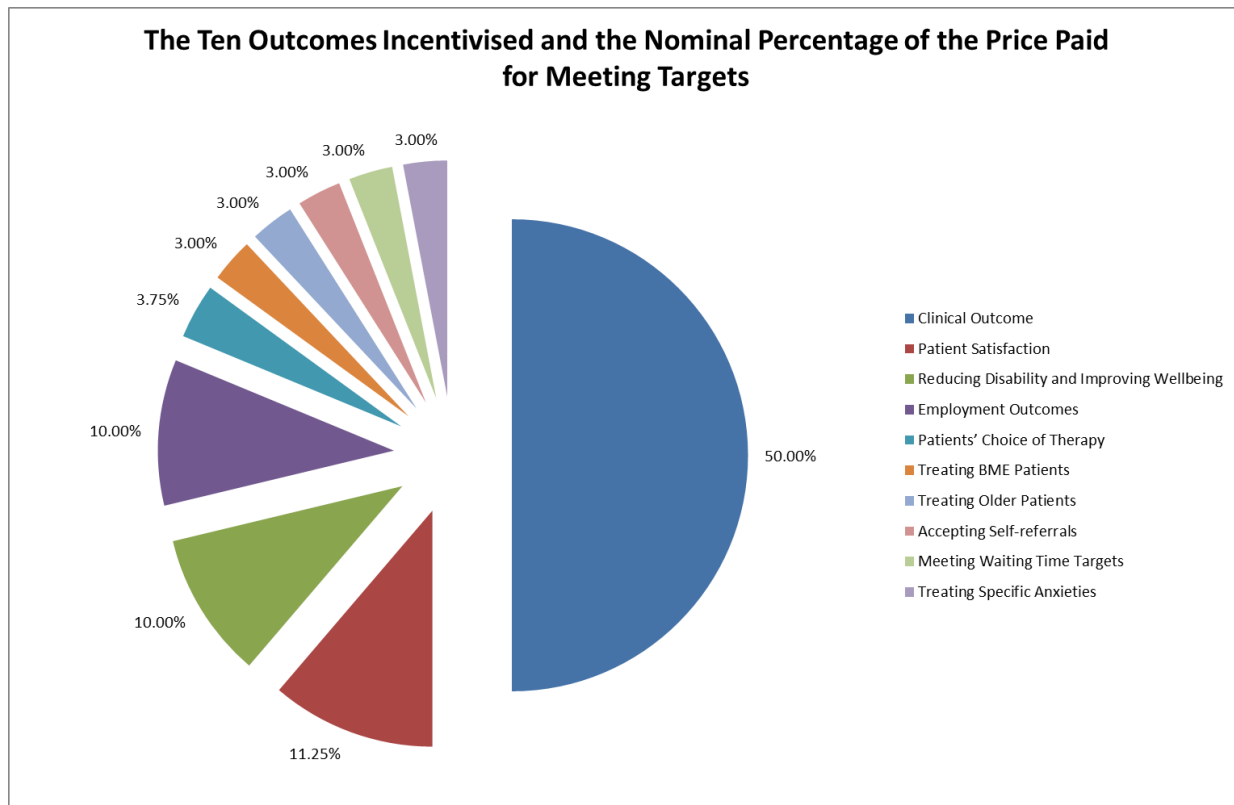
Ten measures are used in the currency design to reflect not only process measures but also clinical and non-clinical service performance. This includes five access targets along with five outcome domains:

- equity of access targets (five measures)
- percentage achieving good clinical outcomes
- percentage with reduced disability and improved wellbeing
- percentage with good employment outcomes
- patient experience
 - satisfaction
 - choice of therapy.

Some elements of the currency model break down to patient level whereas others can only be measured at service level: these will all be calculated monthly on a cohort of patients who have been discharged in the month preceding.

During testing, nominal weights were assigned for each of the ten measures along with nominal targets. In operation it is expected that commissioners, in discussion with providers, will flex and adjust the targets and proportions to meet local needs. A suggested approach is illustrated below which allocates certain percentages of the total price paid for achieving outcomes for particular measures. The ensuing sections elaborate on the individual targets and domains.

Diagram 1: Possible allocation of measures for IAPT outcomes element of payment approach



Equity of access

The equity of access domain is measured at a service level for all the patients discharged each month and breaks down into five measures:

- Was the number of BME patients discharged at least 80% of the expected number? (Given the local prevalence of depression and anxiety in BME people and the proportion of BME people in the local population)
- Was the number of patients, who are aged 65 or over, discharged at least 80% of the expected number? (Given the local prevalence of depression and anxiety in people aged 65 and over and the proportion of people aged 65 and over in the local population)
- Was the number of people discharged who had referred themselves at least 10% of all the discharges?

- Did at least 80% of the people discharged start their treatment within 28 calendar days of their referral?
- Was the number of people treated for a specific anxiety at least 15% of those treated for all anxieties (including general anxiety)?

Of the 15% of payment suggested for access, each attribute could account for 3% of the outcome achievement price as set out in Diagram 1. This will depend on local populations and priorities.

Clinical outcomes

The outcome of treatment is based on comparison of the first and last scores on the relevant clinical scale for measuring symptoms for each patient and is used at each session. There are number of different IAPT scale measures.

Payment is only triggered if the amount of improvement exceeds the minimum that would be considered **statistically reliable**. If change exceeds this amount, the size of the payment will depend on how far the person has moved towards recovery.

All clinical scales have a certain amount of measurement error. A change from one occasion to another is only considered real (i.e. statistically reliable) if it exceeds the measurement error. The amount of first to last treatment change that a patient needs to show on each IAPT measure for the improvement to be deemed statistically reliable is given in the table below.

Table 1 Standardised Clinical Assessment Scales

Measure	Disorder	Range	Caseness	Statistically Reliable Change
PHQ-9	Depression	0-27	10	≥ 6
GAD-7	Generalized anxiety disorder (and unspecified anxiety problems)	0-21	8	≥ 4
OCI	Obsessive-compulsive disorder	0-168	40	≥32 (distress scale)
SPIN	Social Anxiety Disorder	0-68	19	≥10
sHAI	Health Anxiety (short version: 14 items)	0-42	18	≥ 4
MI	Agoraphobia	1-5 (item mean for avoidance alone)	2.3 per item average	≥ 0.73
IES-R	Posttraumatic Stress Disorder	0-88	33	≥ 9

If a patient achieves statistically reliable change (with 0 being the score of someone displaying none of the characteristics of the disorder) **and** recovers then the full clinical outcomes payment is awarded.

If a patient achieves statistically reliable change but does not recover, the following formula will be used to determine the score: - the first score minus the last score, divided by the first score minus the caseness cut off. The resulting fraction will be used to determine what proportion of the payment for clinical improvement should be awarded, ie:

$$\frac{\text{First Score} - \text{Last Score}}{\text{First Score} - \text{Caseness}}$$

If a patient has both depression and an anxiety condition, i.e. is above caseness on the PHQ9 scale and one of the anxiety scales, then the improvement/recovery (or not) in both are taken into account in the calculation of payment.

For those patients admitted and discharged at or below caseness there is no payment beyond the basic service price for each of the mental health clusters that IAPT services are expected to treat and the price for each assessment that the service undertakes. No performance payment based on the clinical outcome can be made as there is no recovery and no statistically reliable change.

Reduced disability and improved well-being- Work and Social Adjustment Scale (WSAS) Outcomes

The WSAS consists of five questions; each question can be scored from 0-8. It is a measure of functional impairment. The first question on Work can be answered Not Applicable.

As with symptom change, change on the WSAS will only trigger a payment if it is sufficiently large to be statistically reliable, this is a movement of 13 or more in the total score. If the change shown by an individual is statistically reliable, then the amount of payment received for that individual will be related the percentage improvement compared to pre-treatment, calculated using the following formula:

$$\frac{\text{First Score} - \text{Last Score}}{\text{First Score}}$$

Employment outcomes

This outcome is measured by whether the commissioner's target has been met for the net numbers moving off of benefits. This is calculated each month by the number who are discharged from the IAPT service who have moved into employment from non-employment or long term sick leave, plus the number who

have moved off of Statutory Sick Pay (SSP), less the number who have moved from employment into non-employment, or on to long term sick and those who have moved onto SSP, divided by the total numbers who have been discharged in the month, times the commissioners target (a percentage). This is shown in the formula below:

$$\frac{\text{Number off of employment or sickness benefits} - \text{Number onto employment or sickness benefits}}{\text{Number of discharges}} \times \text{percentage target}$$

Patient experience

There are two measures of patient experience, choice and satisfaction. These are measured and rewarded separately; however, some satisfaction data are collected at the same time as the choice data (see Diagram 1 for suggested percentages).

There are two points at which patients are asked to provide feedback on their experience. The first is after they have been assessed, a decision to treat has been made and a treatment plan has been put into place. At this point, an assessment questionnaire is administered. This is shown in Annex B. It consists of three questions on choice and one satisfaction question. The use of the satisfaction question in the price calculation is described later in this section. The second point is a post treatment satisfaction questionnaire.

Patient choice

The choice questions are calculated according to the table below. The choice questions each have a yes/no answer, question 3 also has a N/A option. All possible combinations and the associated score are outlined below:

Q1	Q2	Q3	Average Score
Yes	Yes	Yes	3.75%
Yes	No	N/A	3.75%
Yes	Yes	No	1.875%
No	Yes	Yes	1.875%
No	Yes	No	0%
No	No	N/A	0%

Choice is a patient level measure and the overall score achieved divided by the total number of patients submitting questionnaires in the period will be fed into payment calculations.

Patient satisfaction

Each satisfaction question has five options scoring 0 to 4, with four being the most satisfied. The score for each question is shown in the tick boxes for the questions in Annex B.

There are five satisfaction questions at the end of Treatment Questionnaire, and one in the Assessment Questionnaire. Missing answers for any of the six questions are counted as zero.

The total score of the six questions is calculated, and will range between 0 and 24. If the total score is 18 or higher, the 11.25% payment is made for that patient. This target of 18 can be varied if the commissioner in agreement with provider. Patient satisfaction is a patient level measure and the overall score achieved divided by the total number of patients submitting questionnaires in the period will be weighted against absolute numbers completing treatment in the period and fed into payment calculations.

Applying the payment approach

The currency will be used with locally agreed prices in the first instance.

To establish local prices it is important to understand the range of results likely to be achieved. The price will need to be based on both cost and a baseline exercise which looks at historic performance for each of the outcome measures in a preceding period, or where there is a new provider the average achieved locally.

Most of the Access outcome measures should be achievable by a good service, although waiting times may be a challenge in the short term. The price should take this into account as a low performance for waiting times will be in the baseline results.

In the weightings set out in Diagram 1 patient satisfaction accounts for 11.25% of the total available. It is known there is likely to be some skewing of the results, as patients who received very poor or excellent service are more likely to respond than those who received services in line with their expectations. Thus, this is affected by response rates and types of responses. Responses peaked at 16% in the feasibility pilot, but were almost wholly positive. Achieving an agreed response should be part of the pricing model.

The outline model sets a target that 50% of patients will achieve statistically reliable clinical recovery; achievement nationally is currently moving towards this target. Of the remaining 50%, it is expected that a good service will also improve their symptoms by a statistically reliable amount, which means a proportional payment will be achieved. It will be important that providers give the full NICE recommended course of therapy to patients to ensure reliable improvement/recovery. Patients treated who are not above caseness on any clinical scale will attract no payment for the clinical domain under this currency. If commissioners want such patients to continue to be treated then an alternative local currency may be required.

It is known that complexity of patient need as identified from the Mental Health Clustering Tool affects the cost of treatment. People in higher clusters are

significantly more likely to require high intensity treatment. Therefore cluster based episode prices can be used to incentivise treatment of more severe cases avoiding perverse incentives to 'cherry pick' less complex cases.

Determining prices in an outcomes based payment system

Although it is recommended that implementation is at least initially based on a combination of activity payments (for assessments and cluster based treatments) with outcomes payments, the strategic direction should be towards increasing the proportion of payment earned through outcome performance.

The first step in determining a price for a forthcoming year would be to calculate a baseline price for the previous year. Three data items are required: costs, baseline outcomes / access results, and case mix by cluster.

The costs of providing the IAPT service should be calculated by IAPT providers, using the principles described in Monitor's costing guidance which are used for calculating all reference costs. These include the total costs of running the organisation providing IAPT services, including all overheads, where it is a separate enterprise. The total activity will also need to be understood. This is the number of completed episodes of IAPT provided in the reference year.

Operationalising the currency model – outcome based only

For the sake of clarity the example below excludes both payments for assessment and cluster based activity payments.

In a certain health economy providers and commissioners identify the total cost of the IAPT service in the previous year and divide by the total number of completed episodes of care to determine the cost per episode. For the purposes of illustration, say this is £750. This is the Reference Cost.

An assessment of access and outcomes achieved against the domains in the model gives an aggregated performance level of 50%. This is the Outcome Performance Result.

In this example the commissioner and provider have agreed that the payment received will equal the Reference Cost per completed episode / Outcome Performance (where this will always be between 0 and 100%)

Therefore in this example where:

- (i). Reference Cost = £750 per patient and
- (ii) Outcome Performance Result = 50%

The reference price is therefore £1,500.

In this hypothetical health economy the reference price will be the maximum payment due to providers but it will require 100% achievement of the outcomes in order to be earned. This is highly unlikely but it is possible for providers to exceed the 50% performance threshold and it is therefore very important that commissioners understand historic performance levels and the potential for improvement.

The reference cost of £750 in this example, as mentioned above does not take in to consideration any division of the tariff based on Care Cluster or intensity. It is also assumed that there are no changes between the cost levels of the reference year and the pricing (contracting) levels of the billing year. In reality, some adjustment to allow for non-recurrent costs, deficits, NHS inflation factors and commissioning intentions, etc. will be needed. Further guidance on this will be issued in due course.

The currency in operation – further developments

The point of the currency model is to incentivise improved performance across all 5 outcome domains; therefore, in reality, the commissioner will negotiate improved outcome performance with the provider.

In the example the provider has achieved an average of 50% in the reference period. With agreement this might be increased to 55% in the forthcoming year. This can be off-set by simultaneously negotiating cost improvements to reduce the reference price by say 10% in order maintain the cost of services but increase the value delivered. This is obviously a dynamic that should be used constructively to share both risk and reward.

In the example above there is no payment for assessment, activity by cluster, or any recognition that patients at or below caseness will not earn clinical reward. These elements will need to be covered in the local arrangements most likely via activity payments. The model may also need to be modified to reflect differences arising from Care Cluster and intensity of treatment.

In the case of clusters, it will be important to understand the varying costs of providing a package of IAPT for people in each cluster, to help establish a set of cluster based reference prices that recognise the cost of dealing with severity and complexity.

Patients not treated, but only assessed, or with perhaps a single treatment either as part of the assessment or separately, and patients at or below caseness will have no clinical outcome measure and would not be included in the count. The cost of these patients should probably be met separately through an assessment/activity fee or an alternative adjustment to the clinical outcome reward element. Additional guidance will be published to define exactly which patients are included and which excluded alongside reward options.

Further information is available on the IAPT website¹³ on the mechanism that could be used to set local tariffs and incentivise improvement each year. It is also anticipated that through the pilot work undertaken over the last three years indicative average costs will be made available for assessments, non-caseness treatments and cluster based treatments. Over time this information will form part of the annual reference cost collection process.

Additionally, as part of the NHS England programme to develop the outcomes based approach to paying for IAPT services, participating providers and commissioners and HSCIC are working together to develop a computer algorithm to automate the calculation of the payment due each month for each commissioned IAPT service. This tool will have sufficient capacity to take a full year's data and calculate the average achievement of the agreed outcomes and access measures for all of the patients discharged through the year (the currency result).

Finally it is clearly important to ensure that the tariff incentivises complete courses of treatment, as opposed to rewarding single sessions as a means of satisfying access requirements. Current modelling is exploring mechanisms for weighting recovery value against treatment adherence. This will be used to set a baseline. The algorithm and further details on the functioning of the model will be made available during December 2014.

Core enablers

IAPT services teams need to be well integrated across primary, community and acute physical and mental health services. We have identified a number of key enablers that will drive the effectiveness and success of local IAPT services.

As part of the CCG Plan assurance process for 14/15 the following key questions were developed, drawing heavily from fieldwork undertaken by the IAPT Intensive Support Team. This document and other materials are available at:

www.england.nhs.uk/ourwork/sop/plan-sup-tools/iapt-packs/

IAPT assurance questions

- 1) What is the investment in IAPT per annum? An investment of around £58-64 per head of prevalence is likely to be required to reach 15% Access, based on an optimised service for productivity and overheads.
- 2) Does the commissioner fund any other primary care psychological therapy services and does the locality collect IAPT data on all, including primary care counsellor services and charities such as MIND. If not, why not?
- 3) If the CCG is planning an increase in investment from 2014-15, have posts been recruited to? Have training posts been commissioned from Local

¹³ www.iapt.nhs.uk/iapt/

Education and Training Boards, and when will those posts start delivering treatments?

- 4) If the level of investment is not increasing year on year, what exactly is changing and when to increase throughput / productivity and achieve 15% (or higher) access and a minimum 50% recovery rates?
- 5) Are the levels of referrals high enough and the attrition rates low enough to have 15% of prevalence entering treatment? Has the CCG got a clear plan to increase self-referrals and promote/ market the service?
- 6) There is clear evidence that long waiting lists suppress referrals. Is there a plan to clear all waiting lists (additional to the 15% access volume) that will achieve first appointments within 4 weeks for the majority of patients (not an average wait of 4 weeks)? Are hidden waits being tackled once the patient is in the service, such as long waits for particular patient groups, treatments or groups of staff?

High performing services rely on effective commissioning and investment and will be able to respond positively to all the above questions.

Data and information management

Data and information management play a key role in developing and improving services. Collecting, analysing, and interpreting performance information enables providers and commissioners to continuously monitor the impact of the service, to see where the service is working and where it is not, and to identify the associated costs and benefits. Working with patients with both physical and mental health conditions requires effective communication between a number of teams. It is important that this is not impeded by IT systems that are incompatible, and that the appropriate data governance controls are in place when sharing information.

Providers and commissioners need to agree the methods of documenting and sharing information. For example, information sharing protocols should be agreed between the acute hospital provider and the mental health provider to enable the flow of patient information smoothly. Positive action should be taken by healthcare professionals to share information and signpost patients and carers to support that is available locally. Access to information about emotional, social and psychological aspects of mental and physical health, guidance in self-help, and local support services, including housing, should be readily available through a range of channels: leaflets, social media and the internet.

Integrated governance

In any health economy considering adoption of the IAPT payment approach it is advised that an integrated governance group should be established, accountable for the quality of care being provided to patients. Quality and outcomes must be routinely monitored to improve the care being provided. The governance group

should have appropriate representation from primary care, community services and acute physical and mental health services. It should include both clinicians and managers and meet at least bi-monthly or quarterly. The group must review:

- i) the current status of the service
- ii) any risk-related issues and
- iii) must participate in evaluation, audits and implementing any service changes that lead to improvements.

Evaluation

Evaluation is the systematic assessment of the implementation and impact of a service, project, programme or initiative. For providers and commissioners wanting to improve the implementation of any service within their local health economy and to identify the degree to which implementation is successful, it is beneficial to monitor, learn from and evaluate the service. Providers and commissioners may want to evaluate their services in order to:

- Use the data and other information collected through the model to understand whether the benefits being realised outweigh the cost/investment in the service and to make robust decisions on service implementation.
- Refine the existing service implementation model to ensure it delivers the agreed outcomes – this will help to ensure services are flexible and responsive to ‘on the ground realities’ (e.g. changing environment, meeting unmet needs).
- Identify where implementation falls short of best practice and support the roll-out and scale-up of successful approaches.

There are many forms of evaluation that providers and commissioners can use. The approach and methods to the evaluation will depend on the purpose of the evaluation (eg the objectives outlined above), the priorities of the local health economy, as well as the available resources and timeframe. Evaluations should balance theoretical robustness with ‘real world rigour’. The investment in evaluation (eg time, resource, money) needs to be proportionate to the potential benefits the evaluation could generate.

Formative evaluation

Formative evaluation is a method of evaluation that is conducted whilst the service is still in development, usually just after the service has been implemented. This type of evaluation provides decision makers with:

- I. The opportunity to monitor the service performance and if it is meeting its objectives and goals

- II. Highlight any deficiencies and issues that may arise as the service is being provided

Summative evaluation

Summative evaluation methods are conducted once the review period is completed. This type of evaluation tries to elicit information on efficacy, i.e. its ability to do what it was intended to do. Summative evaluations are typically quantitative and assess performance against another standard or benchmark. This type of evaluation offers decision makers the ability to:

- i) look at whether the service is meeting its goals and objectives
- ii) understand both the intended and unintended effects of the IAPT service
- iii) assess the difference the IAPT service is making locally.

Both evaluation methods are recommended as a tool to provide decision makers (providers and commissioners) with ongoing information on the impact of the service at any time point. For each local health economy, the type of evaluation will be dependent on the agreement of the key decision makers. The decision will be made on the basis of the local priorities of the local health economy and also the purpose of the evaluation.

IAPT evaluation

There have been a number of evaluations of the IAPT programme, summaries of progress to date, critiques and commentaries since inception. Perhaps the most authoritative source at this stage is a discussion paper issued by the Centre for Economic Performance in July 2013.¹⁴ The abstract from this is reprinted below:

Abstract

Background: The English Improving Access to Psychological Therapies (IAPT) initiative aims to make evidence-based psychological therapies for depression and anxiety disorder more widely available in the National Health Service (NHS). 32 IAPT services based on a stepped care model were established in the first year of the programme. We report on the reliable recovery rates achieved by patients treated in the services and identify predictors of recovery at patient level, service level, and as a function of compliance with National Institute of Health and Care Excellence (NICE) Treatment Guidelines.

Method: Data from 19,395 patients who were clinical cases at intake, attended at least two sessions, had at least two outcomes scores and had completed their treatment during the period were analysed. Outcome was assessed with the

¹⁴ CEP Discussion Paper No 1227, July 2013 Enhancing Recovery Rates: Lessons from Year One of the English Improving Access to Psychological Therapies Programme'

patient health questionnaire depression scale (PHQ-9) and the anxiety scale (GAD-7).

Results: Data completeness was high for a routine cohort study. Over 91% of treated patients had paired (pre-post) outcome scores. Overall, 40.3 % of patients were reliably recovered at post-treatment, 63.7% showed reliable improvement and 6.6% showed reliable deterioration. Most patients received treatments that were recommended by NICE. When a treatment not recommended by NICE was provided, recovery rates were reduced. Service characteristics that predicted higher reliable recovery rates were: high average number of therapy sessions; higher step-up rates among individuals who started with low intensity treatment; larger services; and a larger proportion of experienced staff.

Conclusions: Compliance with the IAPT clinical model is associated with enhanced rates of reliable recovery.

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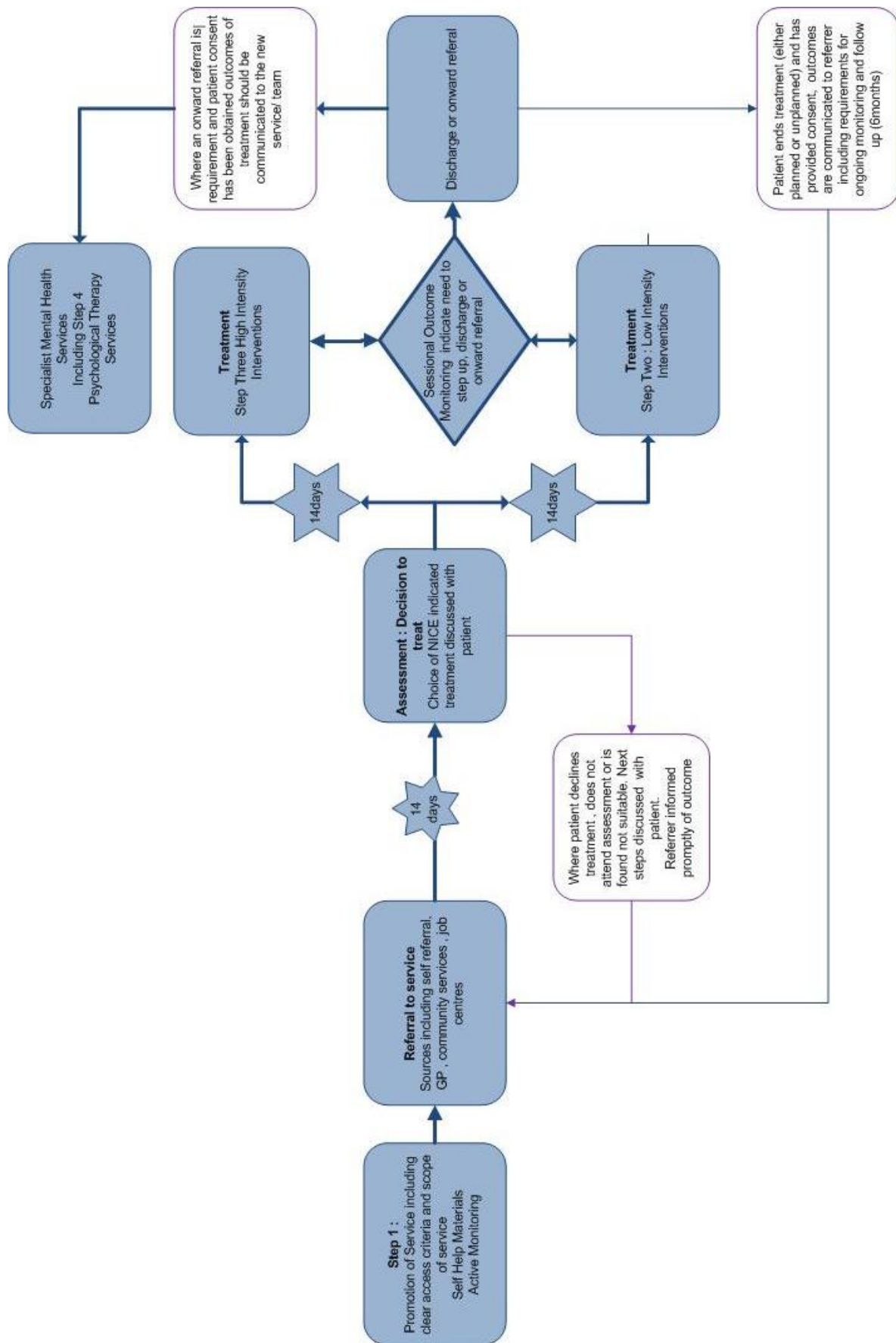
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Annex A: Model of stepped care



Annex B: Patient experience questionnaire

Assessment Patient Experience Questionnaire (PbR)

Please help us to improve our service by answering some questions about the service you have so far received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions.

Please tick one box for each question

<u>CHOICE</u>	YES	NO		
1 Were you given information about options for choosing a treatment that is appropriate for your problems?	<input type="checkbox"/>	<input type="checkbox"/>		
2 Do you prefer any of the treatments among the options available?	<input type="checkbox"/>	<input type="checkbox"/>		
3 Have you been offered your preference?	<input type="checkbox"/>	<input type="checkbox"/>	N/A	<input type="checkbox"/>

<u>SATISFACTION</u>	Completely Satisfied	Mostly Satisfied	Neither Satisfied nor Dissatisfied	Not Satisfied	Not at All Satisfied
1 How satisfied were you with your assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please use this space to tell us about your experience of our service so far

First Name

Surname

Date of Birth

Treatment Patient Experience Questionnaire (PbR)

Please help us to improve our service by answering some questions about the service you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions.

Please tick one box for each question

	At all Times	Most of the Time	Some times	Rarely	Never
1 Did staff listen to you and treat your concerns seriously?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Do you feel that the service has helped you to better understand and address your difficulties?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Did you feel involved in making choices about your treatment and care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 On reflection, did you get the help that mattered to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Did you have confidence in your therapist and his / her skills and techniques?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please use this space to tell us about your experience of our service

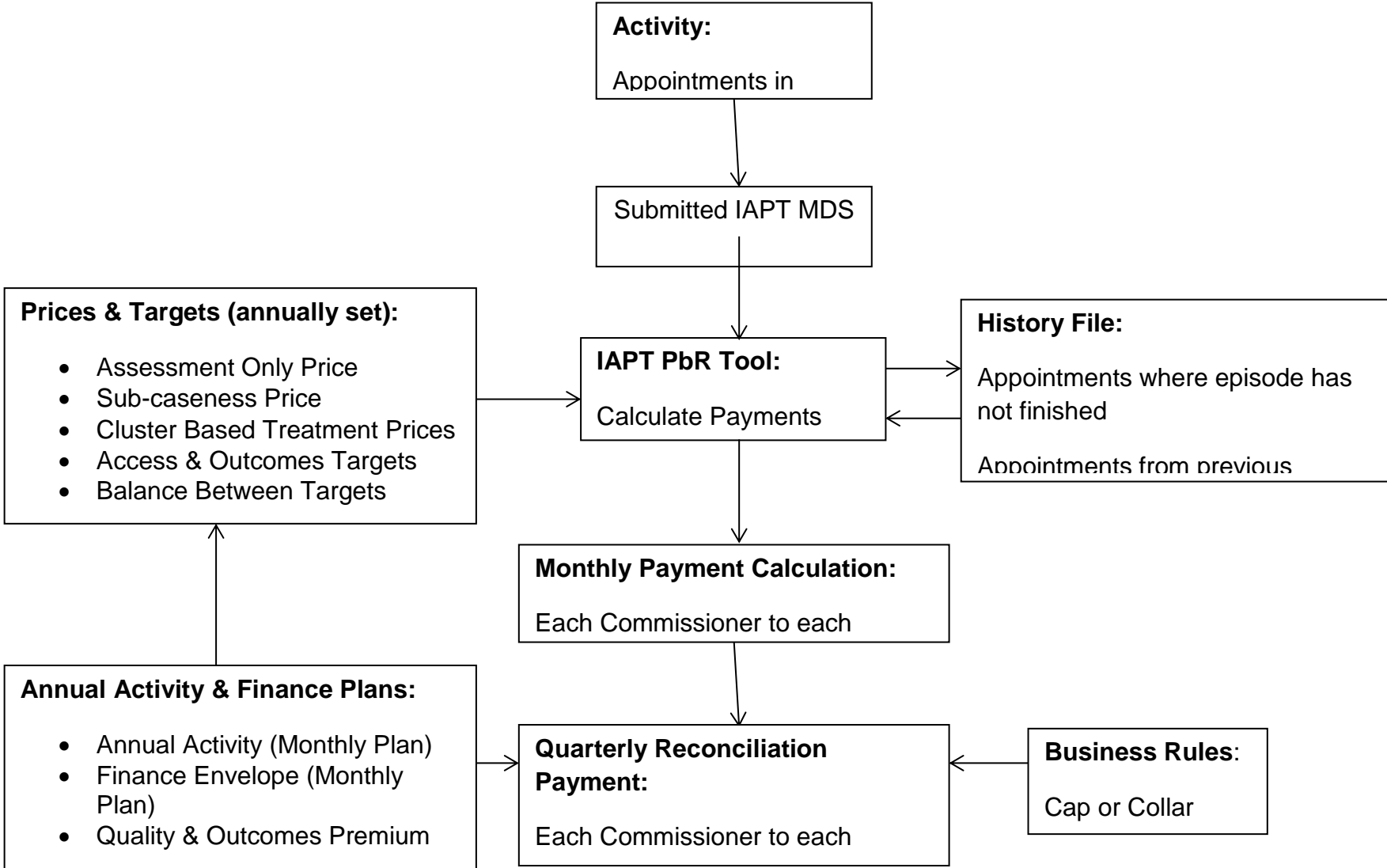
Thank you very much. We appreciate your help.

First Name

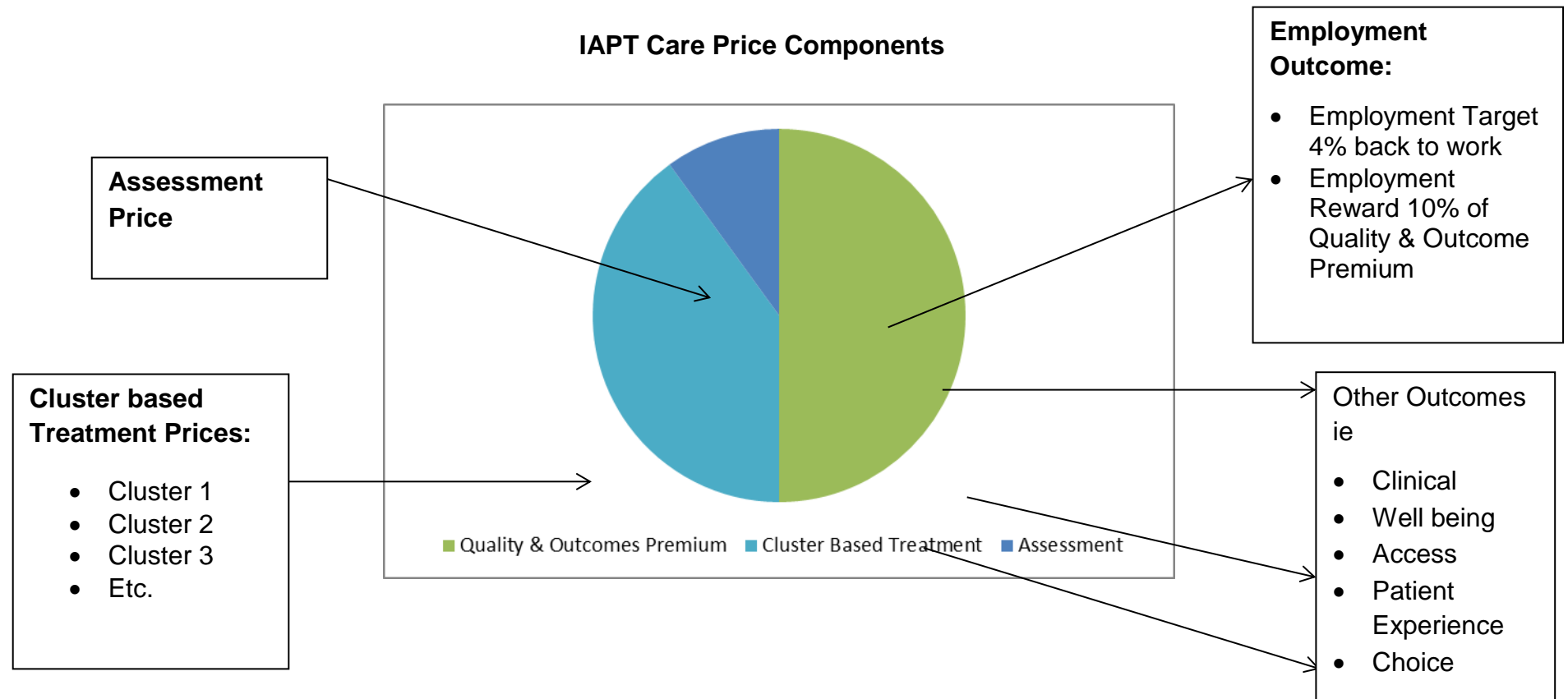
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Annex C: IAPT payment approach



Annex D: IAPT care price components



- If one outcome is more important locally the commissioner can weight this as a higher proportion of the quality premium
- Year on year improvement is obtained by increasing targets

The Quality & Outcomes Premium would start at 50% of total budgeted payments in year one and increase by x% each year over 5 years to a maximum of y% of total budgeted payments. (x & y to be determined)